Background: Association of Coloproctology of Great Britain and Ireland guidelines recommend that self-expanding-metallic-stents (SEMS) should be considered in the management of large bowel obstruction for patients with inoperable malignancy, or to convert an emergency situation into an elective one. We reviewed our practice in the setting of a district general hospital.
Methods: Fifteen patients (7 female, Age mean 74 years, sd ± 10) had a SEMS inserted between December 2006 and November 2009. All had large bowel obstruction or obstructive symptoms due to malignancy. SEMS were inserted using a combined endoscopic-radiological approach. Six (42%) were inserted as an emergency, and nine (58%) electively.
Results: Cancers were located in the descending colon 3 (20%), sigmoid 8 (53%), rectosigmoid 3 (20%) and rectum 1 (7%). Eleven (72%) stents were inserted successfully. Four (28%) were unsuccessful due to inability to traverse the stricture (3), and perforation [1]. Stent patency rates were 11 (100%) at 3 months, 8 (73%) at 6 months, and 3 (27%) at 9 months. Six patients died without further intervention at a mean of 5 (sd ± 5) months.
Conclusions: SEMS play an important in role in the management of malignant large bowel obstruction, and facilities for their insertion should be available in district general hospitals.

EVALUATION OF FINDINGS IN PATIENTS UNDERGOING COLONOSCOPY OR FLEXIBLE SIGMOIDOSCOPY FOLLOWING ABNORMAL BARIUM ENEMA: THE IMPLICATION OF POSSIBLE VERSUS DEFINITE LESIONS REPORTED ON BARIUM ENEMAS

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Introduction: Abnormal barium enemas (BE) account for approximately 7% of all indications for colonic endoscopy (CE) in our unit involving time investment for patients, prolonged bowel preparation and anxiety. The objective of this audit was to determine if CE following BE yielded enough pathologies to justify CE without further review of the BE.
Methods: 91 patients who had an abnormal barium enema as an indication for CE were selected from the endoscopy database between October 2006 and November 2007.
Results: Eleven of 20 (55%) polyps were reported as “definite” and 7/30 (23%) reported as “possible” by radiologists were verified by CE. CE demonstrated 34 polyps, 16 (47%) of which were missed by barium enema. Only 21/34 polyps on CE were adenomas histologically. Of 26 colonic lesions suspicious for cancer, 9 (35%) were reported as “definite” and 17 (65%) as “possible” by radiologists. CE verified 6/9 (67%) in the “definite” and 1/17 (6%) in the “possible” group.
Discussion: Most BE reports necessitating a CE are not definite in their diagnosis. When BE reports are definite for neoplastic lesions, there is a high yield of benign and malignant lesions on CE, when the report is uncertain, the yield for both is less.

BLOOD PRODUCT PREPARATION AND USAGE IN EVAR

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Introduction: Blood product transfusion is a significant cost and complication in endovascular aortic aneurysm repair (EVAR). We assessed blood product preparation and usage in EVAR at our unit.
Methods: Data was collected retrospectively for all primary abdominal EVAR procedures between March 2007 and January 2009 at a single centre. Demographics, procedure details, blood product usage and peri-operative haemoglobin were recorded.
Results: 57 patients underwent primary EVAR procedures during this period of whom 82% were male with a mean age of 74 years (65.6-82.5). 7% were fenestrated. Mean duration of procedure was 196 minutes (110-282) and median length of stay was 7 days (IQR 4-9.5). Mean preoperative haemoglobin was 13.01g/d. 28% of patients required a blood transfusion during their hospital stay with a median of 2 units (IQR 2-5.25) used. No sample was received for group and save in 39% of patients. In 37 % of cases a median of 4 units of blood (IQR 2-6) was cross-matched and not transfused. Median length of stay and duration of procedure was not significantly different between transfused and non-transfused groups.
Conclusions: A significant proportion of patients were transfused following EVAR, however, peri-operative preparation of blood products varied widely with safety and cost implications.

LONG TERM FOLLOW UP OF PLASMA KINETIC TURP

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Introduction: Trans-urethral resection in saline uses bipolar energy for TURP negating the need to use glycine irrigation with its associated complications. We present our 4 year follow up data.
Patients and methods: Between January 2003 and November 2005 68 patients underwent plasma kinetic trans-urethral resection of prostate (pkturp) at our institution. Follow up data was available for 57 patients.
Results: The average resection time for pkturp was 46 minutes (range 20-90) with a mean resection volume of 21.6 g (range 3-66 g). The mean haemoglobin drop following pkturp was 0.89 g/dl (range +0.9 to -2). The average drop in sodium level post operatively was 1.48 mmol/l (range +4 to -12) 57 patients notes were obtained, 17 patients had died since their pkturp of conditions unrelated to their surgery. Questionnaires and International Prostate Symptom Score (IPSS) were sent out to the 40 surviving patients with 28 replies. 25 patients completed post operative IPSS the average score was 5.88 (range 0-22). Three patients required long term catheterisation. 2 required further surgery and 3 are on medication for bladder outflow obstruction.
Conclusions: Pkturp is a safe alternative to standard turp and appears to have a similar efficacy in the long term.

DEFAULT DAY CASE URETEROSCOPY & URETERO-RENOSCOPY: A SINGLE SURGEON EXPERIENCE

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Introduction: Managerial emphasis on increased efficiency drives a move towards more daycase (DC) surgery. Previous studies on daycase ureteroscopy (URS) or uretero-renoscopy (FURS) have been selective. We report our experience of default DC URS/FURS of consecutive patients referred for any reason.
Methods: A case-note review of all patients having URS/FURS, under a single surgeon, over a 2-yr period (January 2008-December 2009). All were listed with the intention to treat as daycase whenever possible. An analysis was performed.
Results: 120 patients were listed for URS/FURS. Indications included diagnostic-56; therapeutic (stones-53, strictures/TCC-11). DC surgery was precluded in 40/120 due to emergency/ high ASA / and social reasons, leaving 80(66%) patients scheduled for DC URS/FURS. Thirteen patients (13/80-16%) required unplanned admission so 67/120 (56%) patients actually had DC surgery. Of these, 43 had URS & 24 FURS with 32 being